BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: Marshal P. Fichman, M.D. Physician's and Surgeon's Certificate No. A 19736 Petitioner	)	Case No. 800-2017-031072

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Benjamin Fenton, Esq., attorney for Marshal P. Fichman, for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on October 7, 2019.

IT IS SO ORDERED: October 7, 2019

Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: Marshal P. Fichman, M.D. Physician's and Surgeon's Certificate No. A 19736 Respondent	MBC No. 800-2017-031072 **ORDER GRANTING STAY** (Government Code Section 11521)

Benjamin J. Fenton, Esq., on behalf of respondent, Marshal P. Fichman, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of September 27, 2019, at 5:00 p.m.

Execution is stayed until October 7, 2019, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: September 27, 2019

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against:	)	
Marshal P. Fichman, M.D.	)	**Case No. 800-2017-031072**
Physician's and Surgeon's Certificate No. A 19736	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 27, 2019.

IT IS SO ORDERED August 30, 2019.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation against:

MARSHAL P. FICHMAN, M.D., Physician's and Surgeon's Certificate A 19736, Respondent

Agency Case No. 800-2017-031072

OAH No. 2018061116

PROPOSED DECISION

The hearing in this matter took place at Los Angeles, California on July 8 through 10, 2019, before Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings.

Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), was represented by Peggie Bradford Tarwater, Deputy Attorney General.

Respondent Marshal P. Fichman, M.D., appeared at the hearing and was represented by Benjamin Fenton, Fenton Law Group.

Complainant moved to seal several exhibits, such as patient medical records, to protect privacy rights. The motion was granted. A separate written order will issue

along with this Proposed Decision. Further, redactions were made in documents when that was a practical way of protecting privacy, such as redacting Respondent's social security number on his C.V, exhibit C.

Evidence was received, the case was argued, and the matter submitted for decision on July 10, 2019. The ALJ hereby makes his factual findings, legal conclusions, and order.

INTRODUCTION AND STATEMENT OF THE CASE

In this action Complainant seeks the revocation of Respondent's license to practice medicine on several grounds. First, it is alleged that Respondent can no longer safely practice medicine because he has suffered cognitive impairment that renders him unsafe. A second claim is that he was negligent in his care and treatment of two patients. In one patient's case it is alleged that he improperly touched his female patient's breasts. In the other patient matter, it is alleged that over a period of months, Respondent was negligent in the care and treatment of a patient with a number of maladies. Other legal theories of relief were asserted, i.e., that he engaged in sexual misconduct with the one patient and that his records were inadequate.

Respondent adduced evidence that he is fit to practice safely, denying the unwanted touching to the one patient, and asserting that his care and treatment of the second was within the standard of care.

Complainant has sustained a number of her claims. Public protection requires that Respondent's license be revoked.

Jurisdictional Matters

1. Complainant brought and maintained the Accusation, First Amended Accusation, and Second Amended Accusation (SAA) while acting in her official capacity.

2. (A) On July 1, 1960, the Board issued Physician's and Surgeon's Certificate number A 19736 to Respondent. At the times relevant to this matter, it was valid. The Certificate is due to expire on August 31, 2019, unless renewed.

(B) Respondent has no record of discipline with the Board, except that his license was ordered restricted after Complainant filed a Petition for an Interim Suspension Order in April 2018. That proceeding was based on some of the allegations made in this matter. The order restricting Respondent's license was issued on May 7, 2018 by Matthew Goldsby, ALJ. Judge Goldsby restricted Respondent to practicing four hours per day, five days per week. Respondent was ordered to obtain a practice monitor as well.

3. The Accusation was filed on May 23, 2018. After it was served on Respondent he filed a timely Notice of Defense, requesting a hearing. He also waived his right to have a hearing on the Accusation within 30 days of its filing. This proceeding ensued, all jurisdictional requirements having been met. Pursuant to Government Code, section 11507, Respondent is deemed to deny the allegations of the SAA by his original Notice of Defense.

4. Respondent has long concentrated his practice on internal medicine and nephrology. He has had privileges at Cedars-Sinai Medical Center (Cedars) for most of his career, and he began his association with that hospital when it was Cedars of

Lebanon Hospital, before its merger with Mount Sinai Hospital. Until recently, he also had privileges with Da Vita Century City Dialysis (Da Vita).

Loss of Privileges

5. (A) Da Vita summarily suspended Respondent's practice privileges effective February 4, 2017. The suspension was not just for the Da Vita facility in Century City, but for other facilities operated by the firm. Da Vita reported that action to the Board pursuant to Business and Professions Code section 805;[1] the report was dated March 7, 2017.

(B) According to the 805 report, the suspension resulted from "immediate concerns for patient safety arising from memory problems and cognitive deficits that were reported initially by Facility staff and confirmed through Da Vita's internal peer review process and evaluation reports provided by Dr. Fichman." (Ex. 10, p. 2.)

6. (A) The Board, through investigator Amber Driscoll, subpoenaed Da Vita's records pertinent to the suspension of Respondent's privileges. While not all of the records were produced—Da Vita asserted privileges—those that were produced shed light on Respondent's condition in 2016 and 2017.

(B) The memory problems and cognitive deficits referenced in the 805 report are disclosed by the records. In September 2016, staff reported incidents of

[1] Further statutory citations shall be to the Business and Professions Code unless otherwise noted. Reports pursuant to section 805 are known as "805 reports."

memory lapses and cognitive issues on Respondent's part. For example, as early as May 2016, staff overheard Respondent asking patients if they were his patients. Later that year, while he was on vacation, one of Respondent's patient's put himself on hospice. When Respondent returned from vacation, he was informed of this event by several people. However, over the next several days following his return from vacation, Respondent asked various staff persons, numerous times, why he wasn't informed of his patient's change from care at the facility to hospice care. In another instance, one staff member noted that Respondent listened for a patient's heartbeat with his stethoscope, but it was around his neck, and not in his ears. (Ex. 12, p. AGO 0022.)[2]

(C) Da Vita's Credentialing and Peer Review Committee (CPRC) developed an action plan for Respondent, which included cognitive and memory testing. That plan was discussed with Respondent in late November 2016, and the testing was to occur within 30 days. Respondent was provided a list of resources for the testing. (Ex. 12, p. 61.) By January 20, 2017, Respondent had not undertaken the testing.

(D) On January 20, 2017, the Da Vita CPRC made it clear that Respondent needed to undergo testing. It was at that point that he informed the Da Vita CPRC that he had already undergone assessment at UCLA, and that a report had been generated. He authorized release of the report.

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[2] Complainant's exhibits are internally numbered with the legend AGO, and a numeral. Unless otherwise noted, further page citations shall be to that AGO number, but will omit the AGO legend, and the zeros that precede the page number.

(E) The CPRC members reviewed the report by UCLA, which had been generated in July 2016, prior to the November 2016 action plan. The UCLA report concluded that Respondent suffered substantial cognitive impairment not compatible with quality patient care, and the report recommended that Respondent cease practicing medicine. The CPRC was rather concerned that the report had not been shared with the committee, even when they sought testing. The CPRC then determined that Respondent's privileges had to be suspended.

7. (A) Effective May 19, 2017, Respondent's practice privileges were suspended by Cedars for reasons similar to those that motivated management at Da Vita in its suspension of Respondent's privileges. Cedars gave notice to the Board through an 805 report dated June 5, 2017.

(B) Cedars staff relied on a fitness for duty report from the University of California, San Diego Physician Assessment and Clinical Education Program (PACE Program) dated May 8, 2017. The report was generated after a three-day assessment of Respondent.

(C) The Cedars' June 2017 805 report stated, in part, that Respondent's staff membership and privileges were summarily suspended because to do otherwise posed an "imminent danger to Medical Center patients." The determination was based on an outside report finding that [Respondent] was unfit for duty based on cognitive defects." (Ex. 13, p. 2.) The report noted that Respondent sought a medical staff hearing, which was then pending.

(D) On February 14, 2018, Cedars gave notice to the Board that the Cedars Board of Directors had upheld a recommendation that Respondent's privileges to practice there be revoked, in the interest of patient safety. The February 18, 2018

report noted that outside reports had deemed Respondent unfit for duty due to a "major neurocognitive disorder and a likelihood of dementia." (Ex. 13, p. 4.)

Assessments of Respondent

8. Since 2016, Respondent has undergone several assessments of his cognitive abilities. The assessments have, with one exception, concluded that Respondent suffers from cognitive deficits that make him unsafe to practice medicine.

9. (A) As noted above, Respondent was assessed at UCLA in July 2016. A report was issued, signed by Christine You, Ph.D. and Robert Bilder, Ph.D., which stated that Respondent suffered from Major Neurocognitive Disorder. (Ex. 15A, pp. 45, 46.)

(B) The team at UCLA performed its evaluation by a neuropsychological status exam by a psychologist, and neuropsychological testing with a technician and with a psychologist. A number of test instruments were utilized.

(C) During the testing phase, Respondent exhibited some of the memory problems that drew the attention of his colleagues at Da Vita and Cedars. For example, before the testing, he spoke to his wife, who was present, about having lunch together, and then forgot the matter by the end of the morning. He repeated statements multiple times during the assessment. He displayed decreased episodic memory during administration of tests. (Ex. 15(A), p. 43.) The assessment team noted a decline in verbal and nonverbal memory from testing that had been performed in 2012, after he had a bout with Guilian-Barre Syndrome.

(D) Respondent did not acknowledge the possibility of then-existing impairments, showing minimal insight to this own functioning and how this could affect his practice. (Ex. 15 (A), p. 45.) Respondent asserted that his anxiety was to

blame for poor test performance on key indicators. The assessment team explained that his performance and his profile could not be explained by anxiety during the process, and they explained to Respondent that he had been amnestic during the testing process.

(E) The UCLA assessment team spoke to Respondent and recommended that given his memory deficits, he should plan for retirement. Respondent did not agree with the results from the testing, referencing his anxiety again. The assessors told him "repeatedly," that such was not consistent with his profile. (Ex. 15(A), p. 47.)

10. (A) As noted above, in April 2017, Respondent spent three days at the PACE Program in San Diego. The PACE Program, generally, is designed to assess physicians for professional shortcomings, and where possible, to remedy such shortcomings through post-graduate education and training. The PACE Program has always had a component designed to assess the physical and mental status of a physician referred to the program. Cedars sent Respondent to PACE in April 2017 for a fitness for duty evaluation.

(B) Respondent was seen by four different specialists at PACE. A number of test instruments were utilized to assess Respondent and an MRI of Respondent's brain was conducted.

(C) The findings made by PACE, and set out in a report dated May 8, 2017, are that Respondent was unfit for duty as a physician. That conclusion was based on a finding that Respondent suffered significant cognitive deficiencies, which interfered with his ability to act as a physician, and that his continued practice would be a danger to the public welfare. The report indicated agreement with the report generated by UCLA. (Ex. 15(A), p. 20.)

(D) One of the assessors at PACE, Kai MacDonald, M.D., commented on Respondent's tendency, during an interview, to repeat pieces of information six or seven times, with no awareness that he was repeating himself. (Ex. 15(A), p. 18.) Respondent demonstrated memory deficits in that interview as well. As detailed below, Respondent demonstrated such behavior during the hearing in this matter.

11. After the Board began investigation of this matter, which was triggered by receipt of the two 805 reports, Respondent agreed to an assessment, physical and mental, by physicians to be designated by the Board.

12. In December 2017, Respondent received a physical exam by Lawrence Dardick, M.D., who did not raise any major concerns with Respondent from a physical point of view. Dr. Dardick did note, however, that based on administration of a test (the Montreal Cognitive Assessment Version 8.1), Respondent exhibited mild cognitive impairment.

13. (A) Nathan Lavid, M.D., a forensic psychiatrist, was tasked with conducting an assessment of Respondent. On December 1, 2017, Dr. Lavid spent over three hours with Respondent. Although Respondent did well on the mini-mental status test, over the course of three hours of conversation and interaction, Dr. Lavid detected significant problems in Respondent's memory. Ultimately, Dr. Lavid diagnosed moderate cognitive deficiencies and Dr. Lavid concluded that it would not be safe for Respondent to continue to practice medicine.

(B) On December 5, 2017, Dr. Lavid issued a report on his assessment of Respondent, which detailed his findings. He testified in this matter as well. His testimony was credible, in terms of both his demeanor and the content of his testimony. Dr. Lavid found that obtaining Respondent's career history was difficult

because of Respondent's memory loss. Respondent's story changed about his history, and Dr. Lavid had to go online and piece together some of the history. Dr. Lavid perceived some fragmented thought process, where Respondent would be discussing one topic and then shift to another. When Respondent couldn't answer a question, he would shift the topic to try to cover for his lack of memory.

(C) Dr. Lavid was in agreement with the UCLA and PACE assessments, in that all three found that Respondent suffers from cognitive impairment, such that he is unsafe to practice medicine. Dr. Lavid pointed to the MRI study from PACE, explaining in lay terms that it showed that Respondent's brain is shrinking. He believes that the MRI results support his (and others') diagnosis of neurocognitive disorder.

(D) At bottom, Dr. Lavid is confident that Respondent cannot safely practice medicine, even with a monitor.

14. Respondent presented the report and testimony of Brian Jacks, M.D., who examined Respondent in April 2018. Dr. Jacks finds some cognitive impairment, but he does not believe it is such that Respondent is unsafe to practice. Dr. Jacks testified on Respondent's behalf to the same effect.

Other Evidence of Respondent's Cognitive Impairment

15. Some of Respondent's office staff have noticed his memory problems. Ms. Bituin Villanueva testified to such in her deposition, which was taken on May 22, 2018, in connection with a civil suit filed by Patient 1 against Respondent. Ms. Villanueva is Respondent's office manager, and has worked for him since 1987. During the deposition, Ms. Villanueva stated that Respondent began to show memory loss approximately eight to twelve months before the deposition, or in 2017. (Ex. 34, [depo] pp. 40, 48, 63.)

16. Another staff person, Barbara Bangoy, gave deposition testimony on May 22, 2018. She testified that Respondent began to exhibit memory problems during the time prior to the deposition. She described how he would give her orders, and then, forgetting he had done so, give her the same order a few minutes later. (Ex. 35, [depo] p. 118.) Another staff person, Rita Bayan, testified that Respondent had exhibited memory problems in the six months before her deposition, which was taken in January 2018. He repeated himself, and patients reported him asking them the same question twice. (Ex. 37, [depo] p. 27.)

17. (A) Daniel J. Wallace, M.D., F.A.C.P., M.A.C.R. has acted as Respondent's practice monitor in compliance with Judge Goldsby's order restricting Respondent's practice. On June 30, 2019, Dr. Wallace wrote a letter report to the Board regarding his visits to Respondent's office on May 31, 2019, and June 28, 2019. On the second visit, he found one hand-written chart that was illegible. Dr. Wallace recounted a conversation with Respondent during the second (June) visit. Respondent asked how a mutual acquaintance, another physician, was doing. Dr. Wallace told Respondent that their friend had died in 1985, a fact that Respondent had forgotten. This especially concerned Dr. Wallace because he reported to the Board that Respondent had been at the man's funeral and had been a pallbearer at the funeral. It was plain that Respondent had forgotten the fact of his friend's death and funeral.

(B) At the end of his report, Dr. Wallace expressed his concerns about Respondent, stating "I am concerned about his well-documented encephalopathy with forgetfulness and perseveration. Dr. Fichman tries really hard to compensate for this. I am not a mental health professional, and I would recommend that the team that evaluated him in the past take another look at his functional capabilities." (Ex. 52, p. 2.)

18. (A) During the hearing in this matter, Respondent exhibited behaviors such as those noted by UCLA, PACE, and Dr. Lavid. His memory was an issue, and there were times it appeared that he was engaging in behaviors that would mask his problems. At one point, on direct examination, his attorney was taking Respondent through his background, education, and work experience, a standard exercise in cases such as this. Respondent had his curriculum vitae (C.V.) in his hands, and he was at times being directed to it to help with details of his history. Respondent, several times, looked at his CV and stated to his attorney that "this (the C.V.) is real good. Can you get a copy of this for me?" or words to that effect.[3]

(B) During his testimony, Respondent stated that one reason he went into medicine was because two of his uncles were doctors. He repeated this statement four or five times, in a manner that was not responsive to questions. He stated that he intended to obtain privileges at two local hospitals, seeming to have no idea that the termination of privileges at Cedars and Da Vita would be an impediment to obtaining privileges elsewhere.

(C) In his direct examination, Respondent had wanted to read from a statement, and he was taken through his assertions in this matter. After his examination, and just prior to argument by the attorneys, he asked to deliver his

[3] This is a mild paraphrasing as the ALJ does not have the benefit of a transcript. However, Respondent stated three or more times that he wanted a copy of his own C.V. While his attorney may have prepared it for this case, that seems doubtful given that Respondent's social security number was on page 1 of the document.

statement. This was allowed, and Respondent repeated much of his direct exam, as if he had not testified.

19. Aspects of his care of Patients 1 and 2, which is detailed below, may be explained by, or be evidence of, Respondent's neurocognitive impairments.

20. The authors of the UCLA and PACE reports, and Dr. Lavid, have explained why good working memory is required of a physician and surgeon. A physician must use what they have learned, and integrate that information with newly obtained information generated by each examination or treatment of a patient. It is clear that Respondent's memory capacity is significantly impaired, both from the observations of others, and the observation of the ALJ.

21. Notwithstanding the opinion of Dr. Jacks, it is clear that Respondent's ability to practice safely is impaired by significant cognitive deficits.

Patient 1

22. On December 29, 2015, Patient 1, who was then an existing patient of Respondent, presented to Respondent because she needed a referral to a podiatrist. She worked in a job that required her to wear high heels, and she was having foot pain. Under her insurance plan, she could not just go to a podiatrist; her treating doctor had to give a referral, so she made an appointment for that day. Patient 1 was 51 years old at the time of the December 2015 office visit.

23. Once at Respondent's office, he wanted to perform a physical, while she just wanted him to look at her foot and send her to a podiatrist. However, Respondent undertook the physical exam and Patient 1 took off her clothing, remaining in her bra

and panties, and got into a gown. It was within the standard of care to perform a physical even though the patient's complaint focused on her foot.

24. Respondent asked, more than one time, if Patient 1 had had a mammogram and she told him she had. She told him that he had seen the report, and that he had communicated the results to her.

25. According to Patient 1, Respondent reached for and touched her breasts, with both hands. There was an office staff person in the exam room at the time, and she testified in her deposition that she did not see Respondent touch Patient 1's breasts.

26. Patient 1 terminated the examination, got dressed and left. She promptly made a complaint to her insurer about the incident, and a police report approximately 10 days later. There is currently a civil suit for damages pending between Patient 1 and Respondent.

27. Respondent denied touching Patient 1's breasts during the exam.

28. Given the conflicting claims regarding this incident, it was not established to the requisite standard of clear and convincing evidence that Respondent touched Patient 1's breasts.

29. As discussed below, Respondent's chart entry for the December 29, 2015 visit by Patient 1 is inadequate in some ways.

Patient 2

30. Patient 2 was a long-time patient of Respondent, having first seen him in 1993. She had significant health problems, including type II diabetes, hypertension,

mental illness, and scleroderma. Respondent had also diagnosed her with adrenal insufficiency.

31. On January 3, 2013, Patient 2 presented to Respondent with a blood pressure of 250/100. She had not seen Respondent in approximately six months, and she was then 51 years old. At the time of the January 2013 visit, she was taking a number of medications, including Diovan for hypertension; Norvasc; Crestor and Zetia to lower cholesterol; Pristiq, an anti-depressant; Glipizide, Januvia, and Metformin to combat her diabetes; and Florinef to treat adrenal insufficiency.

32. Because of her elevated blood pressure, Respondent referred Patient 2 for emergency care, and she went to Cedars where she was hospitalized. Respondent saw the patient in the hospital. Tests revealed a creatinine value of 2, indicative of significantly diminished kidney function. On a subsequent visit, the patient's blood pressure was 140/80. She was taking four blood pressure medications, but there was some indication in the hospital records that she had not been taking her Florinef. After treatment in the hospital, Patient 2's blood pressure was stabilized.

33. In January 2015, the patient returned to Respondent, and her blood pressure was 170/100. She was still taking Florinef. She was admitted to the hospital for the uncontrolled high blood pressure, and a creatinine level of 2.

34. Respondent had diagnosed Patient 2 with adrenal insufficiency, but the basis of that diagnosis is not set out in his treatment notes. It should be noted that staff at Cedars discounted that diagnosis.

35. Patient 2 had severe hypertension, often uncontrolled. Respondent continued to prescribe Florinef to her after her discharge from the hospital in January 2013. The weight of the evidence is that Florinef is contra-indicated for a person with

hypertension, and especially with uncontrolled hypertension such as Patient 2 exhibited. Respondent's prescription of that medication to Patient 2 in these circumstances was an extreme departure from the standard of care.

36. Respondent's notes of his care of Patient 2 do not show that he investigated secondary causes of her uncontrolled hypertension or of some of her other maladies. Hence, the chart indicates that he did not perform a complete evaluation of the complications of her diabetes. This lack of investigation continued over a period of time, and constituted an extreme departure from the standard of care.

Respondent's Record Keeping

37. (A) Respondent generated a note following the December 29, 2015 visit by Patient 1. The record was legible, and created within 24 hours of the visit, which complied with the standard of care.

(B) However, the record states that the patient had enlargement of the "proximal interphalangeal joint on the right." (Ex. 44, p. 3.) Complainant's expert, Dr. Hammes, noted in his report that the quoted entry was not accurate or adequate, as the patient has four such joints, and the specific joint that was enlarged was not specified. This was a deviation from the standard of care.

(C) The portion of the chart note pertaining to the patient's history is deficient because it does not describe typical characteristics of the patient's pain, such as duration and aggravating or alleviating factors. This is a deviation from the standard of care.

(D) It was asserted by Dr. Hammes that the chart note is insufficient because it does not reflect why Respondent wanted to perform a full physical on the

patient. That assertion is rejected given Dr. Hammes' belief that to perform a physical was within the standard of care.

(E) The two deficiencies described above amounted to a simple departure from the standard of care.

38. Respondent's records for Patient 2 did not comply with the standard of care, in that while legible and apparently timely generated, they lacked a rationale for specific therapy for a patient with multiple and complex conditions, nor was there documentation of investigation of possible secondary underlying causes. This was a simple departure from the standard of care.

Other Matters

39. Complainant's witnesses were credible in their demeanor, and the content of their testimony. Respondent's credibility suffered as it appeared that his impaired memory affected his testimony. However, it is not found that he was prevaricating during his testimony.

40. Respondent has had a long and outstanding career in medicine, having practiced in California for nearly 60 years, never having before been on the Board's "radar," and until sued by Patient 1, never having had a malpractice claim against him. He is mainly guilty of having aged, though he is to be criticized for his lack of insight, and his refusal to respond to the advice and counsel of the professionals at UCLA and PACE, who told him that he should retire due to his declining faculties.

LEGAL CONCLUSIONS

Jurisdiction

1. Jurisdiction to proceed in this matter pursuant to sections 2004 and 2227 was established, based on Factual Findings 1 through 3.

Rules of General Applicability

2. The standard (as opposed to the burden) of proof in this proceeding is that of clear and convincing evidence, to a reasonable certainty. *(Ettinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was therefore obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App. 3d 478.)

3. The purpose of proceedings of this type is to protect the public, and not to punish an errant professional. (E.g., *Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) Protection of the public is the Board's first priority. (§ 2229.)

4. (A) The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke, Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.* at p. 67–68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) The testimony of "one credible

witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. "The fact that a jury may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative." (*Hutchinson v. Contractors' State License Bd. of Cal.* (1956) 143 Cal.App.2d 628, 632–633, quoting *Marovich v. Central Cal. Traction Co.* (1923) 191 Cal. 295, 304.)

(C) Discrepancies in a witness's testimony, or between that witness's testimony and that of others does not necessarily mean that the testimony should be discredited. (*Wilson v. State Personnel Bd.* (1976) 58 Cal.App.3d 865, 879.)

(D) "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted -- but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." (*Wilson v. State Personnel Bd. supra*, 58 Cal.App.3d at 877–878, quoting *Meiner v. Ford Motor Co.* (1971) 17 Cal.App.3d 127, 140.)

(E) An expert's credibility may be evaluated by looking to his or her qualifications. (*Grimshaw v. Ford Motor Co.* (1981) 119 Cal.App.3d 757, 786.) It may also be evaluated by examining the reasons and factual data upon which the expert's opinions are based. (*Griffith v. Los Angeles County* (1968) 267 Cal.App.2d 837, 847.)

(F) The trier of fact may reject the testimony of a witness, including an expert witness, even if it is uncontradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The expert's opinion is no better than the facts on which it is based and, "where the facts underlying the expert's opinion are proved to be false or nonexistent, not only is the expert's opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923–924.)

(G) Even when the witness qualifies as an expert, he or she does not possess carte blanche to express any opinion within the area of expertise. For example, an expert's opinion based on assumptions of fact without evidentiary support, or on speculative or conjectural factors, has no evidentiary value and may be excluded from evidence. Similarly, when an expert's opinion is purely conclusory because unaccompanied by a reasoned explanation connecting the factual predicates to the ultimate conclusion, that opinion has no evidentiary value because an expert opinion is worth no more than the reasons upon which it rests. (*Jennings v. Palomar Pomerado Health Systems, Inc.* (2003) 114 Cal.App.4th 1108, 1116.) The bare conclusion of an expert without supporting facts is not entitled to evidentiary weight. (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493.)

(H) The presiding officer in an administrative proceeding may evaluate evidence based on his or her experience or training. (Gov. Code, § 11425.50, subd. (c).)

5. A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. *(Flowers v.*

Torrance Memorial Hospital Medical Center (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; *see* 6 B. Witkin, *Summary of California Law* (9th. Ed.), *Torts*, sections 749, 750, and 774.)

6. The Code does not define just what "gross negligence" means in proceedings of this type. The Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance, supra*, 189 Cal.App.3d at pp. 1052-1053:

> "Gross negligence" is "'the want of even scant care or an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.[page 1053] 563], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)[4]

7. "Repeated negligent acts" is defined as two or more acts of negligence. (*Zabetian v. Medical Board* (2000) 80 Cal.App.4th 462, 468. See also § 2234, subd. (c)(1).)

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[4] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058

8. (A) "Mere error in judgment, in absence of a want of reasonable care and skill . . . , will not render a doctor responsible for unintentional consequences in treatment of his patient." (*Hufman v. Lindquist* (1951) 37 Cal.2d 465, 475.)

(B) In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the "recognized and approved methods." (*Callahan v. Hahnemann Hospital* (1934) 1 Cal.2d 447.) If so, negligence is not shown by evidence that other medicines or treatment might have been employed. (*Jensen v. Findlay* (1936) 17 Cal.App.2d 536.) The mere fact that there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish that the determination to use one of the procedures was negligent. (*Clemens v. Regents of Univ. of Cal.* (1970) 8 Cal.App.3d 1, 13.)

Legal Conclusions Dispositive of the Case

9. It was established that Respondent's certificate is subject to discipline pursuant to section 822, because it was established that he is not safe to practice medicine due to mental or physical illness. This Conclusion is based on Factual Findings 5 through 21, and 39 and 40.

10. It was established that Respondent was grossly negligent in his care and treatment of Patient 2, based on Factual Findings 30 through 36. Therefore, his certificate is subject to discipline pursuant to section 2234, subdivision (b).

11. It was established that Respondent's certificate is subject to discipline pursuant to section 2234, subdivision (c), because he has engaged in repeated negligent acts, based on Factual Findings 29 and 30 through 38.

12. It was not established, by clear and convincing evidence, that Respondent engaged in gross negligence or sexual misconduct with Patient 1, based on Factual Findings 25 through 28.

13. It was established that Respondent failed to maintain adequate and accurate records on two occasions, based on Factual Findings 37 and 38. His certificate is therefor subject to discipline pursuant to section 2266.

14. All other allegations or claims upon which findings of fact or legal conclusions are not made are deemed unproven, or surplusage.

15. Although Respondent has been an able practitioner for over 50 years, it has been established, by clear and convincing evidence, that in recent years he has suffered significant cognitive impairment, such that he is rendered unsafe to practice his profession of physician and surgeon. The evidence indicates that this is irremediable. As early as 2016, able professionals advised Respondent of his situation, and they advised him that he should plan on retirement. He did not do so. The plain sad truth is that public protection requires the revocation of his certificate, to protect the public from potential harm.

ORDER

The physician's and surgeon's certificate, number A 19736, issued to Marshal P. Fichman, is hereby revoked.

DATE: August 8, 2019

DocuSigned by:
Joseph D. Montoya
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JOSEPH D. MONTOYA
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: MARSHAL P. FICHMAN, M.D. 50 North La Cienega Boulevard, Suite 204 Beverly Hills, California 90211-2227 Physician's and Surgeon's Certificate A 19736, Respondent.	Case No. 800-2017-031072 OAH No. 2018040459 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On July 1, 1960, the Board issued Physician's and Surgeon's Certificate Number A 19736 to Marshal P. Fichman, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2019, unless renewed.

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JURISDICTION

3. This Second Amended Accusation is brought before the Board, under the authority of the following provisions of the California Business and Professions Code (Code). [1]

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . . ."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 820 of the Code states:

"Whenever it appears that any person holding a license, certificate or permit under this division or under any initiative act referred to in this division may be unable to practice his or her profession safely because the licentiate's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licentiate to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licentiate and may be received as direct

[1] All further statutory references are to the Business and Professions Code unless otherwise indicated.

evidence in proceedings conducted pursuant to Section 822."

7. Section 822 of the Code states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

8. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a

reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . . .

". . . .

"(f) Any action or conduct which would have warranted the denial of a certificate.

". . . ."

9. Section 726, subdivision (a), of the Code states:

"The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action for any person licensed under this division or under any initiative act referred to in this division."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Inability to Safely Practice Medicine)

11. Respondent is subject to disciplinary action under sections 820 and 822 of the Code in that his ability to safely practice medicine is impaired because he is physically and/or mentally impaired.

12. A report was filed with the Board by DaVita Century City Dialysis, pursuant to Code section 805, indicating that Respondent's staff privileges had been suspended due to immediate concerns for patient safety arising from memory problems and cognitive deficits that were reported by facility staff and confirmed through evaluation. The report was dated March 8, 2017.

13. Cedars-Sinai Medical Center also filed a report with the Board pursuant to section 805, dated June 5, 2017, indicating that Respondent's staff privileges had been suspended based upon a determination that failure to suspend the privileges may result in imminent danger to Medical Center patients.

14. A supplemental report filed with the Board on February 14, 2018, by Cedars-Sinai

Medical Center indicated that its Board of Directors upheld a recommendation of the medical staff hearing committee to uphold the summary suspension and to terminate Respondent's medical staff membership and privileges.

15. A Neuropsychological Assessment Report resulting from testing at the University of California, Los Angeles, dated July 27, 2016, indicates that Respondent has a Major Neurocognitive Disorder and that the results of testing showed significant impairment that is not compatible with quality patient care.

16. Respondent underwent a Fitness for Duty Evaluation at the University of California, San Diego, Physician Assessment and Clinical Education ("PACE") Program on April 5 through 7, 2017. According to the report of that assessment, Respondent underwent a physical evaluation, neurology evaluation, neuropsychological evaluation, and a psychiatric evaluation. The report found that Respondent suffered from significant cognitive deficiencies that interfered with his ability to perform most or all of the duties of his job and that he presented a significant risk to patients. The report concluded that Respondent was unfit for duty. PACE defines "Unfit for Duty" as follows: "Results indicate that presence of illness exists that interferes with the physician's ability to safely perform most or all of the duties of his or her job. The physician presents a significant risk to patients, self, and others. It is unlikely that any reasonable accommodations could be made that would allow the physician to practice safely."

17. Respondent underwent a voluntary mental health examination, pursuant to section 820 of the Code, with N.L., M.D., a psychiatrist. Dr. N.L. issued a report, dated December 5, 2017. Respondent underwent a three-hour Comprehensive Psychiatric Evaluation. Testing included an interview, administration of the Minnesota Multiphasic Personality Inventory – Second Edition; administration of the Beck Depression Inventory, Administration of the Beck Anxiety Inventory, administration of the Folstein Mini Mental Status Examination; review of a CURES report, and urine drug and alcohol testing. Dr. N.L. found that Respondent suffers from cognitive impairment and is unable to safely practice medicine. Dr. N.L. indicated that a physical examination would be warranted to rule out physical conditions that could be contributing to cognitive impairment. Dr. N.L. diagnosed Unspecified Neurocognitive Disorder, Moderate.

According to Dr. N.L., there is no monitoring that would allow Respondent to practice medicine safely.

18. Respondent agreed to a voluntary physical examination. During the scheduling of the voluntary physical examination with L.D., M.D., Respondent required frequent clarification as to the date of the examination. Respondent made an appointment for his physical examination for November 28, 2017. He did not appear for the examination. Instead, on November 28, 2017, he presented to an urgent care center where he was seen by a different physician with a name that sounded similar to that of L.D., M.D. Respondent could not explain how he obtained the information for the urgent care center physician.

19. An Authorization for Release of Medical Information was sought from Respondent to obtain records from the urgent care center. In signing the release, Respondent seemed confused as to the year and month. He initially indicated "12" for the year before correcting to "18." He looked at his phone and wrote "2.5" for the month and date, rather than the correct date, January 5, 2018.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of two patients. The circumstances are as follows:

Patient 1

21. On December 29, 2015, Patient 1 presented to Respondent with foot pain and a request for a referral to a podiatrist.

22. Respondent indicated a full physical was necessary, and Patient 1 declined due to a lack of time and said she would schedule a physical on a later date.

23. Respondent repeatedly asked Patient 1 if she had undergone a mammogram. Patient 1 responded that she had as Respondent had ordered one and reminded Respondent that he had called her with the results.

24. Respondent advised Patient 1 that he needed to check her heart. Without discussing

the nature of the examination or obtaining permission, Respondent grabbed and massaged her breasts.

25. Patient 1 objected and pulled away. Respondent placed his hand in front of Patient 1's face and shushed her. Respondent refused to leave the room to allow Patient 1 to dress.

26. Respondent was grossly negligent in his care and treatment of Patient 1 as follows:

a. Respondent touched Patient 1's breasts in a manner not needed for treatment or assessment;

b. Respondent conducted the examination of Patient 1 in a sexual, rather than medical, manner;

c. Respondent touched Patient 1 without permission and/or explanation.

27. Respondent's acts and/or omissions set forth in Paragraph 26, whether considered collectively or individually, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code.

Patient 2

28. Patient 2 began treating with Respondent in approximately 1993. Patient 2 was seen for treatment of type II diabetes, hypertension, mental illness, scleroderma (an autoimmune disease that involves hardening and tightening of connective tissue), adrenal insufficiency, and complications related to her conditions.

29. On January 3, 2013, Patient 2 presented to Respondent after having not been seen for approximately six months with a blood pressure reading of 250/100. At that time, she was noted to be taking the following: Diovan (used for hypertension); Crestor and Zetia (used to lower cholesterol); Pristiq (an antidepressant); Norvasc (a calcium channel blocker); Glipizide, Januvia, and Metformin (used for treatment of diabetes); and Florinef at 0.1 mg per day (used for adrenal insufficiency). A side effect of Florinef is elevated blood pressure.

30. Due to the elevated blood pressure, Respondent referred Patient 2 for emergency care. Patient 2 presented to Cedars-Sinai Medical Center where she was hospitalized. Respondent consulted with Patient 2 during her hospitalization. Respondent's note indicates the patient "has also been on Florinef 0.1 mg a day."

31. Patient 2's history and physical performed by another physician prior to the patient's January 7, 2013, discharge notes that Florinef will be held and not continued on discharge and further questions whether the patient suffers from adrenal insufficiency. Patient 2 is noted to have elevated creatinine levels which signifies impaired kidney function, hypertension, and Type 2 diabetes.

32. Respondent saw Patient 2 in follow-up on January 17, 2013. At that time, Respondent noted Patient 2 remained on Florinef at 0.1 mg daily. She was continued on previously prescribed medications and told to return in four weeks.

33. Respondent's progress notes for visits with Patient 2 on February 20, 2014, March 10, 2014, July 11, 2014, August 1, 2014, October 17, 2014, October 23, 2014, and January 20, 2015, reflect continued prescribing of Florinef. Her January 20, 2015, progress note reflects that Patient 2 presented with sudden vision loss in her left eye and blood pressure of 190/100. Respondent's advice was an emergency ophthalmology consult, to consider hospitalization and otherwise to return in 48 hours to recheck blood pressure.

34. On January 20, 2015, Patient 2 was again admitted to Cedars-Sinai Medical Center with left central artery occlusion, elevated blood pressure and an elevated creatinine level. At her admission, she was taking Florinef as prescribed by Respondent.

35. Respondent's progress notes do not demonstrate that he investigated the secondary causes of Patient 2's uncontrolled hypertension or conducted diabetic screenings.

36. Respondent's progress notes do not substantiate a diagnoses requiring the prescribing of Florinef and/or do not reflect a rationale for continuing Florinef and/or do not reflect consideration of discontinuation of Florinef.

37. The standard of care for evaluation of difficult to control hypertension is to investigate for secondary causes.

38. The standard of care in investigating uncontrolled blood pressure and deterioration of kidney function in a patient with a diagnoses of scleroderma requires consideration of scleroderma renal crises.

39. The standard of care for evaluation of a long-term diabetic patient is to complete an

evaluation for complications of diabetes, including neuropathy and diabetic foot infections by testing for sensation and evaluating the feet.

40. The standard of care requires discontinuation of Florinef when blood pressure is elevated.

41. Respondent was grossly negligent in his care and treatment of Patient 2 as follows:

a. Respondent was grossly negligent in failing to investigate secondary causes for Patient 2's hypertension and in failing to evaluate Patient 2 for complications of diabetes;

b. Respondent was grossly negligent in failing to consider discontinuation of Florinef or to provide a rationale for its continuation.

42. Respondent's acts and/or omissions set forth in Paragraph 41, whether considered collectively or individually, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

43. Respondent's license is subject to discipline under section 2234, subdivision (c), in that Respondent was repeatedly negligent in the care and treatment of Patients 1 and 2. The circumstances are as follows:

Patient 1

44. Respondent created notes relating to Patient 1's December 29, 2015, visit for foot pain.

45. Respondent failed to document his thought process as to the extent and nature of physical examination required for a patient presenting with foot pain.

46. Respondent failed to document typical characteristics of pain, such as duration, aggravating/alleviating factors, or character that would be necessary in making a diagnosis and in guiding further evaluation and treatment.

47. Respondent noted that Patient 1 had enlargement of the proximal interphalangeal joint on the right but failed to specify which one of the four such joints was involved.

48. Respondent was negligent in failing to create accurate and/or logical notes of Patient 1's visit.

Patients 1 and 2

49. The allegations contained in the Second Cause for Discipline are incorporated here as if fully set forth.

50. Respondent committed repeated negligent acts in the care and treatment of Patients 1 and 2, pursuant to section 2234, subdivision (c), of the Code.

FOURTH CAUSE FOR DISCIPLINE

(Sexual Misconduct)

51. Respondent's license is subject to disciplinary action under section 726 of the Code in that he committed sexual misconduct.

52. The allegations contained in the paragraphs 21 through 26 in the Second Cause for Discipline are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

53. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records.

54. The allegations contained in the Second and Third Causes for Discipline are incorporated here as if fully set forth.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Number A 19736, issued to Marshal P. Fichman, M.D.;

2. Revoking, suspending or denying approval of Marshal P. Fichman, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering Marshal P. Fichman, M.D. to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: May 8, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

LA2018600460